

BULLETIN

AMERICAN COLLEGE OF SURGEONS



September 2002
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Reporting
medical errors

FEATURES

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About the cover...

A recent study of College Fellows shows that most surgeons are willing to take responsibility for and to report errors that they detect. They also largely support the concept of surgical protocols, according to "Reporting medical errors: Variables in the system shape attitudes toward reporting adverse events, (p. 12). However, as authors Lori A. Roscoe, PhD, and Thomas J. Krizek, MD, FACS, demonstrate, surgeons are skeptical about the effects of mandatory reporting systems. Their concerns are largely attributable to the possibility that individuals who are not directly involved in patient care could misuse the information.

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From my perspective

For those of you who may not yet have heard, it is with great sadness that I report that the President-Elect of the College, C. James Carrico, MD, FACS, died on July 25 after a long and gallant battle with cancer. The College has expressed to his wife, Sue, their three children, and other family members the esteem and appreciation that we all held for Jim and for his professional contributions not only to the College, but to the academic institutions where he served.

On page 24 of this issue of the *Bulletin*, Erwin R. Thal, MD, FACS, Dr. Carrico's colleague and friend, offers some personal commentary on Jim's life and work. In this column, I would like to reflect on Dr. Carrico's permanent imprint on the College.

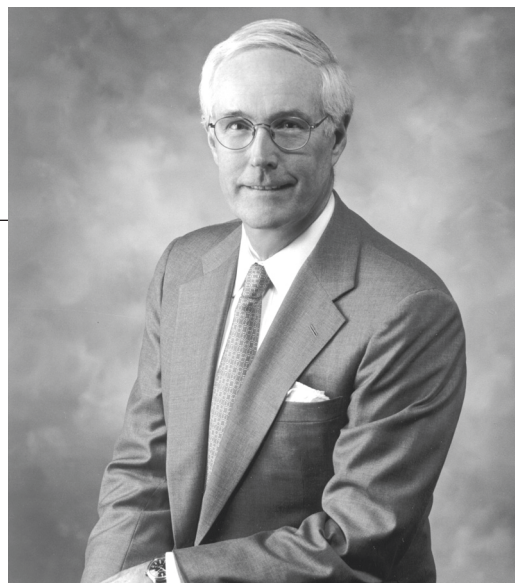
True leadership

Throughout his illness, Jim Carrico remained remarkably attentive to his work and to this organization. He was productive until his last days with us. Although Jim was prepared to die, he clearly was not ready. He was looking forward with great anticipation to becoming President of the College beginning in October and had great plans for his year of presidency.

Whenever those of us who knew Dr. Carrico think about him in the future, we will no doubt express continual amazement at his outstanding contributions to the College. Jim was an indefatigable volunteer throughout his nearly 31 years of Fellowship. In all, he served on 34 different committees, beginning in 1975 when he was appointed to the Pre- and Postoperative Care Committee.

As a specialist in burn, trauma, and critical care, the Committee on Trauma was one of his passions. He was appointed to that committee in 1982 and served as Vice-Chair of its Executive Committee from 1986 to 1989.

Jim was active on the Board of Governors from 1984 to 1990 and served as its Chair from 1989 to 1990. Additionally, Dr. Carrico served three three-year terms on the Board of Regents and was Chair of the Board from 1999 to 2001. In that capacity, he was immensely helpful to me, and I will always appreciate his guidance throughout my early days as ACS Executive Director. He never lectured, offered dissertations,



“I believe one need not look too far to see how Jim Carrico's essence survives in Fellows of the College.”

or harangued about a certain issue. Rather, Jim's advice was concise, direct, always well-received, and most often accurate.

Lasting legacy

No matter what role he was playing at any given time within the College, Jim left a lasting imprimatur. His focus always was on doing what would be in the best interests of the surgical patient and on ensuring that the College's policies and programs would lead to improved quality of care.

For example, he helped to establish and chaired the Committee on Emerging Surgical Technology and Education. Through this committee, he attempted to identify new technologies that would have real clinical applications as well as the best, most appropriate means for training the surgical community in the use of these advancements. I will always associate Jim Carrico with forging this committee, and I believe it will become an even more integral component of the College as we

evaluate the utility of new devices before they are introduced for general use.

Another College committee that grew out of Dr. Carrico's vision and understanding of the modern practice environment is the Health Policy Steering Committee. This committee had Jim's total endorsement as a stepping stone toward the College's development of a more responsive and proactive voice in Washington, DC.

As we enter into the final phases of preparation for the 2002 Clinical Congress in San Francisco, I am reminded that Jim's fingerprint will again be evident on some significant aspects of the program. For example, the Congress will be one day shorter this year than it has been in the past, and, on the front end of the program, we will be combining the Opening Ceremony with the American Urological Association's lecture.

Jim always felt that one of the most important events at the Clinical Congress was the Convocation and the induction of the new Initiates. To that end, he felt strongly that the reception following the Convocation should include ample time and opportunity for the Initiates and their families to meet the College leadership to help foster the lifelong relationship we hope all Fellows will build with this organization. Thus, this year, we will be welcoming and encouraging all of the new Initiates to meet the leaders of the College and other Fellows at the reception on Thursday evening following their induction.

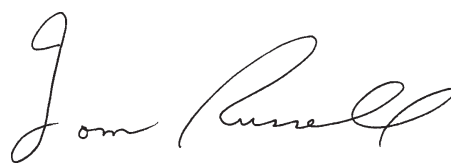
In his memory

Because of the severity of his illness, Jim knew he would be unable to complete his term as President-Elect of the College. So he suggested, and the Board of Regents enthusiastically agreed, that Richard R. Sabo, MD, FACS, the First Vice-President-Elect from Bozeman, MT, should complete Jim's term as President-Elect. Under the terms of the Bylaws of the College, when the President is unable to serve his or her term, the First Vice-President is to serve in that capacity. Thus, once Dr. Sabo is sworn in as First Vice-President during the Convocation ceremonies on October 10, he will then assume the office of President for the year 2002 to 2003. Prior to his death, Jim and Richard had many discussions regarding the goals of the College for the next year, and we anticipate that Jim's vision

and direction will be well carried out despite his physical absence.

I believe that this year's Clinical Congress will be a fitting tribute to Jim Carrico in many ways and can assure you that, in general, the meeting will be of great interest. It will cover a wide range of topics from the scientific to socioeconomic, and we will present 30 finely designed postgraduate courses.

While we will always miss Jim's vision and dedication to our College and will remain indebted to him for the many changes he spearheaded through his quiet leadership, I believe one need not look too far to see how his essence survives in Fellows of the College. We see it in each Fellow who sacrifices his or her time to share an expertise by volunteering to work on committees, to write articles and letters for publication in the *Bulletin*, and to speak at educational meetings. Dr. James Carrico's spirit lives on in your dedication to surgery and to this organization.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

ACS Executive Director Thomas R. Russell, MD, FACS, hosted a meeting of the surgical specialty societies in Chicago on July 12. Of particular interest, the groups agreed that the College should circulate a coalition letter to the Accreditation Council for Graduate Medical Education (ACGME) expressing support for provisions in a workgroup document that would **allow some flexibility in the enforcement of resident duty hour limits**. That letter, which was signed by 19 national organizations, was sent to ACGME on August 1. The coalition letter can be found on the College's Web site at: <http://www.facs.org/dept/hpa/views/gme.html>.

The Candidate and Associate Society of the American College of Surgeons (CAS-ACS) invites all residents, residency program directors, and Associate Fellows attending the Clinical Congress in San Francisco to attend a **symposium on professionalism** and how it is taught in the medical educational environment. The symposium will be held on Sunday, October 6, 2002, from 2:00 to 5:00 pm at the Moscone Convention Center. The speakers will be Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the College's Division of Education, and Michael E. Whitcomb, MD, senior vice-president for medical education and director, division of medical education, Association of American Medical Colleges. Dr. Whitcomb is also editor-in-chief of *Academic Medicine*, the leading journal devoted to issues relevant to academic medicine. There will be an open-microphone discussion following their presentations. For more information, contact phaar@facs.org.

Dr. Russell and LaMar S. McGinnis, Jr., MD, FACS, one of the College's representatives to the American Medical Association's House of Delegates, met with the **Executive Committee of the AMA's Board of Trustees** on July 16 to discuss issues related to advocacy and the organization's relationships with specialty and state societies.

The **25th Annual Residents Trauma Paper Competition** of the College's Committee on Trauma (COT) is scheduled to take place on March 13, 2003, at the COT's Annual Meeting. The "Call for Abstracts" and the "Guidelines for Submission" are posted at <http://www.facs.org/dept/trauma/papers.html>.

The College's insurance program administrator now offers **medical insurance for members traveling abroad**. For details, contact the plan administrator via e-mail at usia-ac@usi-administrators.com or via phone at 800/433-1672. For an online quote, log onto <http://www.acs-insurance.com>, click Medical Plans, then Travel and Global Medical Plan.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

Medicare and liability solutions elude the Senate

Throughout the summer, the U.S. Senate debated Medicare prescription drug coverage. A variety of proposals were considered, but none garnered the 60 votes needed to pass. One amendment that was offered, not specific to the drug benefit issue, was a medical liability reform proposal. Authored by Sen. Mitch McConnell (R-KY), the amendment contained all the medical liability reforms the College and other specialty societies support, except for a cap on noneconomic damages. Unfortunately, the proposal failed when it was tabled by a vote of 57-42. The College continues to advocate for the passage of the comprehensive medical liability reforms contained in the HEALTH Act that was introduced by Rep. Jim Greenwood (R-PA) as H.R. 4600 and by Sen. John Ensign (R-NV) as S. 2793.

Although the Senate did not follow the House and pass a prescription drug bill that included at least an interim solution to the crisis in Medicare physician reimbursement, leaders vowed to renew their efforts when Congress returns from its August recess after Labor Day.

Tort reform moves in Nevada

In response to the severe professional liability crisis in Nevada, the governor called a special session of the legislature to pass tort reform. Following the session, which ran from July 29 to August 1, the governor signed a bill that:

- Caps noneconomic damages at \$350,000, except in cases of gross malpractice or where the court finds there is clear and convincing evidence that the award should exceed the cap because of exceptional circumstances.
- Implements expert witness standards.
- Makes a defendant severally liable for economic damages.
- Extends to physicians in all trauma centers and emergency rooms a cap on civil damages of \$50,000 for care of a traumatic injury demanding immediate medical attention.

In addition, medical facilities will be required to report sentinel events to the state repository for health care quality assurance. Such information will be inadmissible as evidence in any administrative or legal proceeding. Surgeons interested in the text of the legislation should visit the Nevada legislature's Web site at http://www.leg.state.nv.us/18thSpecial/bills/AB/AB1_EN.pdf.

Senate approves \$5 million for trauma systems

On July 18, the Senate Appropriations Committee approved \$5 million for the Health Resources and Services Administration's (HRSA's) Trauma-Emergency Medical Services program for fiscal year (FY) 2003. This program provides federal grants to assist states in planning, developing, and implementing statewide trauma care systems. The funding was included as part of the annual spending bill for the Departments of Labor, Health and Human Services, and Education. The House has yet to act on its version of the appropriations bill. For FY 2002, Congress provided \$3.5 million for the trauma program, which has now been distributed.

In addition, the College is working with the 107th Congress to reauthorize the program for an additional four years and to emphasize the needs of trauma care systems as the nation addresses its ability to respond to acts of bioterrorism. In June, President Bush signed H.R. 3448, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, which includes a provision that authorizes increased funding to “develop and implement the trauma care component of the State plan for the provision of emergency medical services.”

Carmona confirmed as Surgeon General

The Senate confirmed general surgeon Richard H. Carmona, MD, FACS, as U.S. Surgeon General without opposition or debate on July 23. This confirmation cleared the way for Dr. Carmona to assume the position vacated by David Satcher, MD, in February.

EMTALA requirement clarified

Since the enactment of the Emergency Medical Treatment and Active Labor Act (EMTALA), there has been a great deal of confusion about its applicability to various locations on and off the hospital campus. In the final 2003 Prospective Payment System (PPS) rule released on August 1, the Centers for Medicare & Medicaid Services (CMS) clarified that EMTALA applies only to those provider-based departments that are located on the main campus, and that EMTALA does not apply to provider-based entities, such as rural health clinics, that are on the hospital campus. CMS also announced that it needs more time to review the 600 comments it received on the issue, so other changes to EMTALA that were published in the May 9 proposed PPS rule will be addressed in a separate *Federal Register* notice. For more information, visit: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2002_register&docid=page+50081-50130, and scroll down to page 50090.

What surgeons should know about...

Health data resources

by Cynthia Kay Sykes, Office Manager, Washington Office, Division of Advocacy and Health Policy

In the last several years there has been a veritable explosion in the quantity of electronic data sources. The data have been gathered, organized, and stored by a small number of individuals working for different organizations. Here are several Web sites that Fellows may find useful in their efforts to search the Internet for information on various issues. A brief explanation of the types of information available through each site and other contact information is provided whenever possible.

Acronyms and Initialisms for Health Information Resources

<http://www.geocities.com/~mlshams/acronym/>

Acronyms for global information and data resources on health, medical, and veterinary sciences.

Agency for Healthcare Research and Quality Office of Health Care Information

<http://www.ahrq.gov/data/>

Data from the medical expenditure panel survey and health care cost and utilization project quality indicators.

Clearinghouse phone: 800/358-9295
Address: Executive Office Center, Suite 501, 2101 E. Jefferson St., Rockville, MD 20852

Agency for Toxic Substances and Disease Registry

<http://www.atsdr.cdc.gov>

HazDat database, measuring health effects, minimal risk levels, child health.

Phone: 404/498-0110 or 888/422-8737
Fax: 404/498-0057

Association of Public Data Users (APDU)

<http://www.apdu.org>

Resources for the identification and application of public data, establishment of links between data users and producers, and data policy issues.

Contact: Teresa Hall Allen, Chief Administrator
Address: P.O. Box 12538, Arlington, VA 22219
Phone: 703/807-2327
Fax: 703/528-2857
E-mail: TeresaH@smdi.com

Association of State and Territorial Health Officials

www.astho.org

State data standards, reports, surveillance, and statistics.

Address: 1275 K St., NW, Suite 800, Washington, DC 20005-4006
Phone: 202/371-9090
Fax: 202/371-9797

Bureau of Labor Statistics

<http://www.bls.gov>

Safety and health statistics.

Cancer Statistics Review 1973-1993

<http://seer.cancer.gov/>

This report includes incidence, mortality, and survival data from 1973 through 1993.

Centers for Disease Control and Prevention (CDC)

<http://www.cdc.gov>

This agency of the Department of Health and Human Services maintains a site that provides access to a variety of data. Sections on traveler's health, data and statistics, diseases, injuries, health risks, specific populations, and prevention guidelines and strategies are included. Most of the CDC's periodic publications are available free through this site.

CDC National Center for Health Statistics

www.cdc.gov/nchs/

Address: 6525 Belcrest Rd., Hyattsville, MD 20782

Phone: 301/458-4636

CDC National Prevention Information Network

<http://www.cdcnpin.org>

The CDC National AIDS Clearinghouse's services are "designed to facilitate the sharing of HIV/AIDS, STD, and TB resources and information." A service of the CDC, this site features health information divided into categories such as online tutorials, databases, and a poster gallery. It also provides access to some CDC publications.

CDC, Youth Risk Behavior Surveillance System Results

www.cdc.gov/nccdphp/dash/yrbs/ov.htm

State and national results from a continuous survey of risk factors and youth.

Phone: 800/311-3435

E-mail: HealthyYouth@cdc.gov

Clinical Alerts and Advisories

http://www.nlm.nih.gov/databases/alerts/clinical_alerts.html

Clinical alerts and advisories from the U.S. National Institutes of Health expedited release of research findings that could significantly affect patient morbidity and mortality.

Clinical Trials Listing Service

<http://www.centerwatch.com>

The site is designed to be a resource for patients interested in participating in clinical trials, physicians who have patients who might benefit

from inclusion in a trial, and for research professionals. It includes an international listing of more than 5,200 clinical trials actively recruiting patients. You may search the database by disease and geographic region.

ClinicalTrials.gov

<http://www.clinicaltrials.gov/>

The U.S. National Institutes of Health and the National Library of Medicine collaborate to provide this searchable database of clinical research studies.

Combined Health Information Database

<http://chid.nih.gov>

Titles, abstracts, health information, and health resources.

Computer Retrieval of Information on Science Projects

http://commons.cit.nih.gov/crisp3/Crisp_Query.Generate_Screen

CRISP includes information on the projects found in *ClinicalTrials.gov* and information about nonclinical trials as well.

Fatality Analysis Reporting System

www.nhtsa.dot.gov/people/ncsa/fars.html

Data on causes of fatal traffic accidents.

FEDSTATS

<http://www.fedstats.gov>

More than 70 federal agencies produce statistics of interest to the public. The Federal Inter-agency Council on Statistical Policy maintains this site to provide easy access to the full range of statistics and information produced by these agencies for public use.

Food and Drug Administration
<http://www.fda.gov>

Phone: 202/783-5555
Fax: 202/783-1583

Food and Nutrition Information Center (USDA)
<http://www.nal.usda.gov/fnic>

National Association of Health Data Organizations
www.nahdo.org

Food and Nutrition Information Center (USDA) is one of several information centers at the National Agricultural Library. This site provides access to FNIC's databases and resource lists, along with food and nutrition links.

Address: 375 Chipeta Way, Suite A, Salt Lake City, UT 84108
Phone: 801/587-9104
Fax: 801/587-9125
E-mail: info@nahdo.org

Centers for Medicare & Medicaid Services
<http://www.hcfa.gov/stats/>

National Institutes of Health (NIH)
www.nih.gov

If you are looking for information on diagnosis-related groups or the free computer programs available to assist you in preparation of accurate claims, this site may provide the information you need.

NIH Information Index
www.nih.gov/health/InformationIndex/HealthIndex/Pubincov.htm

Medical Yellow Pages
www.medsite.com

Diseases currently under investigation by NIH, NIH-supported scientists, major NIH research areas, and important health-related topics.

Categorized health data.

National Library of Medicine
<http://www.nlm.nih.gov>

National Association for Public Health Statistics & Information Systems
www.naphsis.org

Practice guidelines

Address: 1220 19th St., NW, Suite 802, Washington, DC 20036
Phone: 202/463-8851
Fax: 202/463-4870
E-mail: hq@naphsis.org

Primary Care Clinical Practice Guidelines
<http://medicine.ucsf.edu/resources/guidelines/>

National Association of Counties
www.naco.org/counties/counties/index.cfm

Site located at UCSF that links the user to guidelines made available on the Web by many different organizations and journals (emphasis seems to be given to full-text online). When summaries, abstracts, complete documents, and/or PDF versions are available as alternate forms the site lists links to each form separately. The guidelines are organized by organ system, but are also available through search and alphabetical index features.

County-level demographic and other data.

National Association of County and City Health Officials
www.naccho.org

National Guideline Clearinghouse
<http://www.guideline.gov/index.asp>

Public health advocacy information, data alliance project, and publications.

Evidence-based clinical practice guidelines from a searchable database. Some of the resources obtainable through this site are several hundred pages long.

Address: 1100 17th St., 2nd Fl., Washington, DC 20036

Clinical Practice Guidelines, Quick Reference Guides for Clinicians, and Consumer's Guides from the National Library of Medicine

<http://text.nlm.nih.gov/>

Reference material

Dictionary.com

<http://www.dictionary.com/>

Access to an online English dictionary, the online version of Roget's *Thesaurus*, and lists of links to dictionaries in other languages.

Dictionary of Cell Biology

<http://on.to/cellbiology>

Quick access to definitions of terms frequently encountered by those reading the modern biology literature. The Web site provides access to the third edition of the dictionary, which was published in 1999.

Merriam-Webster Online Dictionary

<http://www.m-w.com/dictionary.htm>

Online version of the collegiate dictionary and the collegiate thesaurus.

Taber's Online Medical Dictionary

<http://www.rxlist.com/cgi/tabersearch.cgi>

You will need to scroll to the bottom of the page to see the search box if you have a small computer screen.

The White House—Health-Related Resources

www.whitehouse.gov/government/handbook/health.html

Online health-related resources from the U.S. government comprised of the following major sections: leading causes of death in America; prevention; health care; health and environment; alcohol, smoking, and other drug information.

U.S. Census Bureau

www.census.gov

Census State Data Centers; current population estimates and projections; current economic indicators; National Center for Health Statistics; National Health Data Standards; CDC Wonder; Monthly Vital Statistics Report.

Phone: 301/763-4636

Fax: 301/457-4714

U.S. Department of Commerce: National Technical Information Service (NTIS)

www.ntis.gov

Databases, resources, *Statistical Abstract of the United States*.

World Health Organization Statistical Information System

<http://www.who.ch/whois>

Describes and, to the extent possible, provides access to statistical and epidemiological data and information presently available from the World Health Organization and elsewhere in electronic or other forms. 

Disclaimer: Inclusion of a Web site here does not constitute ACS endorsement of the site's contents.

Reporting medical errors:

Variables in the system
shape attitudes
toward reporting

adverse
events

by Lori A. Roscoe, PhD,
and Thomas J. Krizek, MD, FACS,
Tampa, FL

Surgeons are seriously concerned about the prevalence of medical mistakes. Medical errors can injure or kill patients, ruin professional reputations and careers, endanger the trust that patients have in medical care professionals, and are costly.¹ Two large studies, one in New York and one in Colorado and Utah, found that adverse events occurred in 3.7 percent and 2.9 percent of hospitalizations, respectively.²⁻³ The results of these studies imply that between 44,000 and 98,000 patients die each year as a result of medical errors, which exceeds the eighth leading cause of death (suicide) in the U.S.⁴

These retrospective studies most likely relied on medical chart review by physicians and nurses and, therefore, may have significantly underestimated the magnitude of the problem.⁵ A report by Dr. Krizek in the July 2000 *Bulletin* anticipated and reviewed this situation and detailed the data from a study performed earlier at the University of Chicago.⁶ Those data were derived from a prospective observational study, which found that 46.9 percent of 1,047 patients in surgical intensive care units experienced an adverse event; 17.7 percent of the patients experienced a serious event that was defined as threatening either to life or limb.⁷⁻⁸

While medical error may be a prevalent and serious problem, medical mistakes may also be the best source of data about how systems may be improved to avoid them. Most medical errors are described as “organizational accidents,” because they most often result from problems within complex organizational systems, not from individual mistakes.⁹⁻¹⁰ A recent Institute of Medicine report about medical errors and patient safety included a recommendation that, in addition to the mandatory reporting of patient deaths and serious injuries attributable to error, hospitals establish voluntary reporting systems for tracking errors that may expose patients to risk but do not necessarily result in serious injury (“near-misses”).¹¹

The success of voluntary reporting systems that track a full range of adverse events depends on the willingness of health care professionals to identify and report such events. When errors are discovered the most likely response is to punish the individual most directly associated with the error, even though errors generally result from interactive causes rather than from individual negligence.¹² The entire culture of surgeons and of sur-

gery has been challenged by these recommendations, and concerns about surgeon reaction were raised by Dr. Krizek in his Ethics and Philosophy Lecture at the 2001 Clinical Congress of the College.¹³ Thus, while it appears that voluntary reporting of errors and near-misses may provide the data needed for system-wide improvements, resistance to such voluntary error reporting systems may be grounded in fears that such data would be misused or would result in litigation.

This pilot study sought to assess surgeon characteristics and case-specific circumstances that may influence the voluntary reporting of adverse events. The specific aims of this project were: (1) to assess surgeons’ attitudes about reporting adverse events; and (2) to determine the individual characteristics and situational factors that may influence whether errors are reported or concealed.

Study methods

A total of 783 surveys were sent to a random sample of surgeons listed in the American College of Surgeons 1998 *Yearbook* with the only exclusion criteria being that those selected had to be listed as practicing medicine in the U.S. A total of 218 completed questionnaires were returned and analyzed (yielding a response rate of 28%). The questionnaire was three pages long and required about 15 minutes to complete.

Participants were asked to read about two scenarios in which an adverse event occurred during the surgical management of a patient and were asked to respond to a series of yes-or-no questions. The scenarios varied in terms of the harm to the patient, the relative ease with which the error could be concealed, the age of the patient, and how directly the surgeon was involved in the medical mistake. Participants were asked to respond to both cases regardless of whether the case situations were reflective of their particular practice pattern.

Participants also were asked to indicate their age, their gender, the state in which they practice, their specialty, and whether they currently supervise medical students and/or residents. Two open-ended questions sought opinions on whether surgical protocols lessen the chance that errors will occur during surgical management of patients (in-

cluding preoperative, intraoperative, and postoperative), and what effect mandatory reporting systems may have on reducing the incidence of surgical errors.

The average age of respondents was 50.5 years (minimum 38, maximum 85), and 91 percent were male. When the 5 percent of respondents who indicated that they were retired were excluded, the average age was 49.2 years (minimum 38, maximum 68). Participants were in surgical practice in 41 states, with 10 percent from Florida and 10 percent from New York. The majority of respondents indicated that they were general surgeons (36%), with 12 percent specializing in plastic surgery and 8 percent in otolaryngology.

Nearly half of the respondents were in specialty group practices (44%), 31 percent were in solo practice, 18 percent were associated with academic health centers, and 7 percent practiced in HMOs or the Veterans Affairs system. Sixty percent of respondents supervised medical students and/or residents.

The findings

The first case presented to the respondents was as follows:

An 80-year-old woman has an indurated area in her breast at the site of a breast biopsy (negative for cancer) performed six months ago. During your exploration, under local anesthesia, in your own office surgical facility, you discover that a 4 x 4 sponge had been left in the site and represents the cause of the firmness. There is no evidence of cancer in the breast. Since your assistant was distracted at the time you discovered the foreign body, there are no witnesses.

Most respondents (99%) believed that the discovery of the sponge should be shared with the patient, and 90 percent believed that they had a responsibility to report the finding of the sponge to the facility where the biopsy was originally performed. Only 1 percent of the respondents reported that the age of the patient was a factor in whether or not they would report the adverse event, with the comment that older patients may be less likely than younger patients to pursue litigation against physicians.

A quarter of respondents (26%) indicated that they believed reporting the incident to the patient would result in litigation against them, regardless of where the initial surgery was performed. Two-thirds of respondents (62%) believed that reporting such events would result in improved patient care in the future.

The second case presented to the respondents was as follows:

A 45-year-old man had closed fractures of the tibia and fibula of the same lower extremity and multiple other injuries. The cast you applied has become too tight as swelling occurred over the last 12 hours. Since the patient was not conscious, any changes in sensation could not be determined, and the nurses and residents did not recognize the changes in the color of the foot. Despite release of the cast pressure by you, the patient has subsequently shown a persistent peroneal nerve palsy on that side; months later it appeared that his foot-drop would be permanent.

The majority of respondents (84%) felt that as “captain of the ship” they were most responsible for the complication described in this scenario, and 86 percent felt that the incident should be reported to the hospital and other agencies responsible for the quality of patient care. Three-quarters of respondents (75%) indicated that having strict protocols for the management of patients with multiple injuries would lessen the occurrence of complications such as the one described in the case study, and 66 percent felt that surgeons caring for patients with apparently similar problems should follow the same protocol.

Impact of surgical protocols

In addition to offering their responses to the two cases just described, study participants were asked whether they believe surgical protocols lessen the chance that errors will occur during the surgical management of patients and whether they think mandatory reporting systems would help to reduce the incidence of errors.

Approximately 75 percent of respondents indicated that they believe that the use of surgical protocols would lessen the incidence of errors. Many qualified their comments with statements such as,

“protocols best fit straightforward procedures,” “errors will occur in spite of protocols,” and “there needs to be room for individualization depending on circumstances.”

Participants who believed that protocols would not affect error rates commented that errors typically result from lack of training and personnel shortages, rather than the absence of protocols or standard procedures, and that the use of protocols may encourage staff to “stop thinking.” Several respondents indicated that protocols may be a two-edged sword: while they may reduce errors, they also may encourage litigation if they are not precisely followed, regardless of whether adverse circumstances result. Further, surgeons may assume that protocols are being followed because they exist, while their existence may not be obvious to substitute or “float” personnel.

Mandatory reporting systems

Nearly half of the respondents felt that mandatory reporting would affect errors. Some respondents supported their views with statements such as: “There will always be errors when humans are involved”; “mandatory reporting systems only make it easier for lawyers to gain access to data”; and “mandatory reporting is no substitute for a good relationship between doctor and patient.”

Approximately one quarter of the respondents said they believed that mandatory reporting of errors would have a positive effect and may reduce errors. Respondents indicated that reporting systems may make physicians more vigilant, adding that “anytime that a process is monitored or measured, it tends to improve,” and mandatory reporting “makes patients feel that the institution and physicians are interested in their well-being and are making an attempt to reduce errors.”

About 15 percent of the respondents indicated that they didn’t know how reporting systems would influence errors. Some respondents indicated that the impact would depend on the establishment of entirely new systems and would be unlikely to be effective if they were “added on” and nothing else was changed.

The remaining 10 percent of respondents indicated that they believe that instituting mandatory reporting systems may have a negative effect on the handling of medical errors. Common objec-

tions to mandatory reporting cited in the study included: (1) it may increase the pressure to conceal, rather than analyze, errors; (2) reporting is unworkable given the current legal system; and (3) it may not result in constructive solutions, just more punishment or censure, which ultimately fail to reduce errors.

Conclusions

Patient safety and the reduction of errors in medical care are important issues. The results of this survey indicate that these issues are important to surgeons, and that the majority of surgeons feel a responsibility to report adverse events to patients and to their institutions, as well as to assume personal responsibility for the safety of their patients.

Yet there is evidence that medical errors occur at epidemic levels and that the current system in most hospitals and clinics requires that blame be

“Opposition or reluctance to report errors is not likely due to deficiencies in the character, values, or competence of individual surgeons, but rather to the systems-level variables and conditions that constitute current medical care delivery systems.”

placed and punitive sanctions be imposed on those most closely associated with the mistake. Punishments range from mortification in front of one's peers at a morbidity and mortality conference to more lasting hardships, such as the loss of one's license to practice medicine.

These results begin to clarify that opposition or reluctance to report errors is not likely due to deficiencies in the character, values, or competence of individual surgeons, but rather due to the systems-level variables and conditions that constitute current medical care delivery systems. The way in which medical care is provided, particularly in the operating room, makes it unfair to assign blame to the surgeon only. By the time the surgeon enters the operating room to remove a diseased limb, for example, many other decisions have been made, such as which limb to expose and how the plan of care has been documented in the medical chart. If the wrong limb is operated on, the entire system is at fault, not solely the individual surgeon. Blaming and punishing the surgeon most closely associated with the error is not a substitute for analyzing the entire work flow, from patient admission to discharge, to uncover procedures that should be modified and changed to prevent further similar incidents.

The current culture of blame and litigation also works against the use of voluntary error reporting. As several respondents indicated, until the legal system is changed to protect physicians' rights and hospital administrators' rights to maintain private data on errors and near-misses, it is less likely that such data will be collected and analyzed.



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Yet these data provide the best opportunity available for addressing the system-wide weaknesses or latent errors that may pose greater recurring threats to patient safety than singular incidents of personal incompetence.

The analysis of trends in medical errors and of repeated mishaps, as well as the development of protocols and the implementation of standard procedures, may lead to safer patient care. As one respondent said of the first scenario, "What OR doesn't count sponges? If your standard procedure is to count sponges, such mistakes cannot occur." It is a sad fact that even though almost all institutions may now monitor OR equipment and materials on a routine basis, sponges and instruments continue to be left in surgical patients, even when the count was either reported as "correct" or the report of "incorrect" was ignored. Factors such as the critical shortage of nurses, temporary or float personnel in high-risk areas such as the operating or emergency room, and even cost pressures may be factors that influence the ability of committed medical professionals to limit errors.

While overall these results support that surgeons are motivated by professional values such as responsibility, duty, and altruism, surgeons must be willing to identify colleagues who are careless with patients, whether due to substance abuse, outdated skills, or indifference. Systems problems in no way absolve from blame or censure individuals who are negligent or incompetent.

Respondents had reservations about mandatory reporting systems and about the development and implementation of surgical protocols as ways to reduce the rates of adverse incidents. Both approaches have limitations, some of which were highlighted in comments from survey respondents. Mandatory reporting systems may expose individuals to censure instead of being used to understand system-wide patterns. Surgeons may not be willing to follow protocols, and protocols may be less useful in some surgical procedures or at some hospitals or surgical facilities than at others.

This pilot study methodology also has limitations that must be addressed before generalizing these results to other populations. A response rate of 28 percent is acceptable for this type of "unofficial" study; a study sponsored, for instance, by the American College of Surgeons would no doubt encourage a broader response. When cases similar

to this were used at ethics colloquia at the Clinical Congress, a larger percentage of surgeons indicated they may have been tempted to conceal the finding of the sponge. The use of hypothetical scenarios to elicit opinions about controversial subjects was supported; the response rate was acceptable and the resulting data yielded meaningful results.

This pilot survey of practicing surgeons was conducted to elicit their approach to two hypothetical situations in which error led to adverse consequences. Almost all surgeons believe that issues of error need to be shared with patients and, to a somewhat lesser degree, with the institution. A majority of surgeons support more widespread use of protocols, particularly on the more common procedures. There is widespread concern about the legal consequences of mandatory reporting and the conflict between an ethical duty to address adverse events and the punitive consequences from reporting. 

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References

1. Thomas EJ, Studdert DM, Newhouse JP, et al: Costs of medical injuries in Utah and Colorado. *Inquiry*, 36:255-264, 1999.
2. Brennan TA, Leape LL, Laird NM, et al: Incidence of adverse events and negligence in hospitalized patients: Results of the Harvard medical practice study I. *N Engl J Med*, 324:370-376, 1991.
3. Thomas EJ, Studdert DN, Burstin HR, et al: Incidence and types of adverse events and negligent care in Utah and Colorado in 1992. *Med Care* (in press).
4. Centers for Disease Control and Prevention: Deaths: Final data for 1997. *Natl Vital Stat Rep*, 47:27, 1999.
5. Thomas EJ, Studdert DM, Brennan TA: The reliability of medical record review for estimating adverse event rates. *Ann Int Med*, 136:812-816, 2002.
6. Krizek TJ: Surgical error: Reflections on adverse events. *Bull Am Coll Surg*, 85(7):18-22, 2000.
7. Andrews LB, Stocking C, Krizek T, et al: An alternative strategy for studying adverse events in medical care. *Lancet*, 349:309-313, 1997.
8. Krizek TJ: Surgical error: Ethical issues of adverse events. *Arch Surg*, 135:1359-1366, 2000.
9. Reason J: Human error: Models and management. *BMJ*, 320:768-770, 2000.
10. Chassin MR, Becher EC: The wrong patient. *Ann Int Med*, 136:826-833, 2002.
11. Kohn LT, Corrigan JM, Donaldson MS (eds): *To Err Is Human: Building a Safer Health System*. Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academy Press, 2000.
12. Bosk CL: *Forgive and Remember: Managing Medical Failure*. Chicago, IL: University of Chicago Press, 1989.
13. Krizek TJ: Ethics and Philosophy Lecture: Surgery...Is it an impairing profession? *J Am Coll Surg*, 194(3):352-366, 2002.

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For the past few years, the American College of Surgeons has been expanding its advocacy efforts to include greater involvement in state legislative and regulatory issues. Fellows and chapters have indicated in membership surveys and during visits from College leadership and staff that they would like the College to be more supportive of their efforts to advocate in their state legislatures. In fact, a 2001 survey of the chapters indicated strong support for the College's development of advocacy resources for use by chapters, such as sample letters to legislators, fact sheets, issue briefs, and so on.

This article highlights some of the advocacy resources the College has created so far to assist Fellows and chapters in their federal and state advocacy efforts. Most are available for easy access on the College Web site, primarily the Division of Advocacy and Health Policy's home page (<http://www.facs.org/dept/hpa/index.html>). Because this is an ongoing and dynamic process, it is important that surgeons regularly visit this site to check on updates to issues, publications, resource materials, and so on. Web addresses for the other resources mentioned in this article are listed in the box on page 19.



ACS offers advocacy resources

by Jon H. Sutton, State Affairs Associate,
Division of Advocacy and Health Policy

Advocacy resources

Grassroots advocacy sometimes seems to be a confusing and frustrating effort. A lack of information about an issue, unfamiliarity with the “how-tos” of legislative advocacy, uncertainty about the effects of advocacy activities, and the idea of squeezing one more activity into an already busy schedule can make grassroots lobbying an intimidating proposition. However, the following Internet resources should help.

- **Staff:** The College has committed considerable staff resources to its Division of Advocacy and Health Policy. This Division is involved in numerous socioeconomic issues and activities. Its Web page contains links to information for College-sponsored CPT coding workshops, practice management courses, and the CPT coding hotline, as well as a complete list of Division staff, including contact information and areas of responsibility. Calling a staff person in the Division is a good first step toward learning more about an issue, getting advice on which legislators or government officials to contact, and so on. The Washington Office, which handles all federal activity, can be contacted at 202/337-2701. Questions about state legislative or regulatory issues should be directed to Christopher Gallagher, Manager, State Affairs, in the College’s Washington Office, or Jon Sutton, State Affairs Associate, in the College’s Chicago Office at 312/202-5358.

- **Legislative Action Center (LAC):** This simple, user-friendly Web-based advocacy tool is an excellent way for surgeons to advocate on their behalf. The LAC requires entry of a zip code, which helps identify federal legislators. It contains action alerts on such issues as Medicare payment, trauma funding, and federal tort reform, and provides sample letters to legislators that can be sent by e-mail directly from the action center. These letters are easy to modify to reflect a surgeon’s personal situation and the effect proposed legislation could have on his or her patients. Also, the LAC conveniently links a surgeon to his local media outlets (newspapers, magazines, television and radio stations), so that surgeons can get the message out to the public and to patients, who can serve as effective advocates on any issue.

While the Legislative Action Center currently is structured to address federal issues only, the College anticipates that a state legislative component

will be added by the end of this year. When this new service becomes available, chapters will be able to direct their members to action alerts for issues popping up in their state legislatures.

- **State issues database:** This database provides surgeons and chapters with important information on proposed state legislation and regulation, including bill number and subject, legislative provisions, and bill status. The database is searchable by state, issue, legislative text, or date. Because new bills are added on a regular basis, and

Web addresses

Division of Advocacy and Health Policy

www.facs.org/dept/hpa/index.html

ACS Advocacy and Health Policy staff

www.facs.org/dept/hpa/staff.html

Legislative Action Center

<http://capwiz.com/facs/home/>

State issues database

<http://web.facs.org/statelegislative/default.htm>

Tips for communicating with legislators

www.facs.org/dept/hpa/tips.html

State legislature Web sites

www.facs.org/dept/hpa/statesites.html

Publications on socioeconomic issues

www.facs.org/dept/hpa/pubs/pubs/html

ACS views on particular issues

<http://www.facs.org/dept/hpa/views/views.html>

Other resources

www.facs.org/dept/hpa/otherres.html

Scope of practice action kit

www.facs.org/dept/hpa/scopeofpractice.html

Professional liability action kit

<http://www.facs.org/dept/hpa/proliability.html>

others are periodically updated, surgeons are encouraged to regularly visit this database.

- *Communicating with legislators:* Critical to grassroots advocacy is effective communication with legislators and other government officials. Whether communication is conducted in written or oral form, it is important to understand and follow a few simple “do’s and don’ts” for writing letters, talking with a legislator, or setting up a meeting. These tips are easily printed for sharing with colleagues, who should be encouraged to contact their legislators when an action alert is sent out.

- *State legislature Web sites:* Each state legislature has a Web site that contains volumes of information relating to bill status/history and text, pages for state senators and representatives, and lists of legislative committees and their hearing schedules. They can also serve as tools for identifying an individual’s elected officials, reviewing voting information, and so on. Fellows should visit their state’s Web site and become familiar with the various features and information available.

- *Publications on socioeconomic issues:* It is important to know in advance of communicating with policymakers exactly what to say about an issue. To help surgeons understand socioeconomic issues, for many years, the College has published articles, health policy briefs, and newsletters highlighting state and federal issues. By visiting the link listed on page 19, surgeons can find these items in one convenient place. In addition, ACS views on particular issues are available.

- *Other Internet resources:* Searching the Internet for anything may be a frustrating and time-consuming experience, with thousands of hits on any one topic. To help narrow the focus, the College’s Web site identifies some useful legislative Internet sites, as well as links to the legislative/governmental relations pages of the national surgical specialty societies. All these items are found at the Web site listed above.

Chapter-focused resources

One issue that came to the College’s attention earlier this year was that of single-degree oral surgeons working to revise the definition of the practice of dentistry to expand their scope-of-practice into cosmetic surgery of the head and neck. To assist chapters in responding to these efforts (and

to provide them with a warning that this situation could happen in their states), the College developed and distributed a scope of practice action kit. It provided a briefing on the issue and suggestions for advocacy activities, such as contacting state dental boards to be placed on their meeting mailing list, working with state specialty and medical societies, and communicating with state legislators.

The College also developed a professional liability action kit to help chapters and Fellows deal with the current malpractice insurance crisis. Fellows from around the country have noted problems with rapidly increasing professional liability insurance premiums or with their ability to purchase insurance at any price. The kit details a series of action steps, including writing legislators, governors, and insurance commissioners (with sample letters to follow) and working with state medical and surgical specialty societies through coalitions. It also provides contact information for various groups, individuals, and entities. Finally, the kit contains some sample letters for use in contacting local media outlets (easily accessible through the Legislative Action Center described earlier in this article).

The professional liability action kit has its own Web page. Be sure to visit it and make use of its materials when it comes time to push for tort reform in your state.

Final thoughts

Advocacy efforts need to begin now in order to prepare for the 2003 state legislative sessions. Whether the issue is scope of practice, tort reform, Medicare payment, regulation of office-based surgery, or one of particular concern in a specific state, legislators and other government officials need to know how these policies affect the practice of surgery and access to care. Visit the College Web site to find out the latest on a particular issue and new action alerts for the Legislative Action Center. Check your e-mail regularly, as this is often the fastest way to alert Fellows and chapters about contacting legislators. □

Statement on residency work hours

In January 1994 the American College of Surgeons published its recommendations concerning "Surgical Residencies and the Educational Environment" (Bull Am Coll Surg, 79[1]89-93). The following statement addresses the specific issue of residency work hours and the importance to patients of professionalism and continuity of care. It also highlights the need to improve working conditions and the educational environment for all surgical residents so that they can provide care of the highest quality to their patients. This statement was developed by the Candidate and Associate Society of the American College of Surgeons and was approved by the Board of Regents at its June 2002 meeting.

Surgical residency is first and foremost an educational experience based on direct patient care. Implicit in a residency program is the principle that all patient care provided by residents is safe and well supervised. Patients have a right to expect a healthy, alert, responsible, and responsive physician.

It is, therefore, inappropriate for teaching hospitals to rely upon residents to perform tasks that are not directly related to either education or patient care. These demands threaten the educational system and are a principal reason for excessive work hours. It is essential that hospitals provide sufficient support personnel to perform these noneducational tasks. It is also essential that residents be provided with appropriate support and supervision from faculty who exemplify professionalism in all aspects of patient care and interpersonal interactions. Finally, there must be comfortable facilities in which residents may rest, eat, and study, as well as opportunities outside the work environment for personal development.

Quality patient care, now and in the future, is dependent on quality graduate education. It is critical that the work environment be monitored, modified, and optimized in order to achieve this important goal.

In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

Since this series began, the U.S. Department of Health and Human Services has issued additional clarifications about the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). As originally proposed, the HIPAA privacy regulation would have required every practice to develop and provide several forms to patients. The use of some of these forms, including the consent form, is now optional. This month's column begins our look at the required documents.

Authorization form

Each practice should develop a patient authorization form. The form is not required to treat all patients, but in some instances physicians must request and receive authorization. The authorization process provides the patient with the opportunity to ask questions, to negotiate how their information will be used and disclosed, and ultimately to control whether these uses and disclosures will be made. A patient must sign the authorization form before a practice may use or disclose information for most purposes beyond treatment, payment, and health care operations.

According to HIPAA, payment means all the activities performed by a practice to obtain or provide reimbursement for the provision of health care. Hence, payment includes determinations of eligibility or coverage under a health plan, billing, claims management, collection activities, and related health care data processing.

A practice does not need authorization to release necessary information to health plans and their agents and business associates of the practice. Authorization is not required to disclose information directly relevant to a family member or any other person identified by the patient, if that person is involved with the patient's care or payment for health care, unless the patient has requested that such disclosure not be made and you have agreed.

Authorization is not required if the patient is incapacitated or in an emergency situation and, in your professional judgment, the disclosure of the information is in the best interests of the patient.

Authorization does not apply if use or disclosure is required by law (that is: public health activities; reporting victims of abuse, neglect, or domestic violence; reporting decedents and their organ, eye, or tissue donation; law enforcement purposes and judicial and administrative proceedings; or efforts to avert a serious threat to health or safety). Authorization will be required for the disclosure of any confidential information to life insurance companies, automobile insurance companies, or workers' compensation carriers.

An authorization form must use plain language and should include the patient's name, date of birth, and identification number. Each authorization must specify the release under consideration, so the form should allot space for entering that information. The form also should include the following "core elements":

- A description of the information to be used or disclosed.
- Identification of the individuals authorized to use or disclose the protected health information.
- Identification of who will receive protected information.
- A description of each purpose of the use or disclosure.
- An expiration date or event for the authorization.
- Any special privacy provisions included in state law. A good resource for links to state privacy regulations can be found on the National Association of Insurance Commissioners Web site (<http://www.naic.org/1privacy>).
- The patient's signature and date or, if the form is signed by a personal representative, a description of his or her authority to act for the patient.

In addition, the authorization form is not valid unless it contains the following information regarding patient rights:

- The patient may revoke the authorization in writing. This revocation may be accomplished in either of two ways: (1) through a statement regard-

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Socioeconomic tips of the month

Understanding local medical review policies

by the Division of Advocacy and Health Policy

In addition to understanding CPT and ICD-9-CM coding, surgeons and their staffs also should be aware of the regulatory variables that affect reimbursement. Most physicians are familiar with the Medicare correct coding initiative edits, which cause certain procedures to be incorporated, or bundled, into other procedures and a decrease in anticipated reimbursement.

Some other factors may affect acceptance of your Medicare claims as well. In some cases, the Centers for Medicare & Medicaid Services (CMS) issues a national coverage policy for a procedure. (To access the current Medicare national coverage policies for medical procedures and diagnostic tests, go to http://www.hcfa.gov/pubforms/06_cim/ci00.htm.) If there is no CMS policy, Medicare carriers may develop local medical review policies (LMRPs) to provide reporting standards for procedures. Both types of policies describe the circumstances for Medicare coverage for specific medical service procedures or devices.

A LMRP explains the clinical circumstances under which a service would be covered, correctly coded, and considered medically reasonable and necessary. The policy generally contains:

- A detailed description of the procedure.
- Diagnoses and a list of the ICD-9-CM codes that support the medical necessity for the procedure.
- Reasons why the carrier will consider the procedure a covered service.
- Coding guidelines.
- Documentation requirements.
- National statutes and guidance that could affect the carrier's coverage policies.
- Reasons for denial of a claim for the service.
- Sources of the information (medical literature, the advice of local medical societies and medi-

Around the corner

October

- 2003 ICD-9-CM code changes effective October 1. The 90-day implementation period during which Medicare will allow claims to be submitted with the 2002 and the 2003 ICD-9-CM code versions begins.
- Quarterly update to 2002 Medicare fee schedule effective October 1.
- Quarterly update to 2002 Correct Coding Edits effective October 1.
- ACS-sponsored basic coding workshop for surgeons on October 8, during the Clinical Congress in San Francisco, CA. To register for PG25, go to <http://www.facs.org/clincon2002/index.html>.
- Health Insurance Portability and Accountability Act (HIPAA) transaction compliance plans must be submitted to CMS electronically or postmarked by October 15, 2002. To access and download the form or to file electronically go to <http://www.cms.hhs.gov/hipaa/hipaa2/default.asp>.

cal consultants, and public comments) the carrier considered in developing the coverage determination.

- All effective and revision dates and the rationale for revising the policy.

All LMRPs may be viewed at <http://www.lmrp.net>. They are posted by carrier and can be downloaded as zip files.

Application of LMRPs

LMRPs only apply to claims that are submitted to the carrier issuing the policy. A LMRP may not conflict with a Medicare national coverage decision once that coverage decision is effective. How-

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College news

In memoriam

C. James Carrico: Farewell to a friend

by *Erwin R. Thal, MD, FACS, Dallas, TX*

On July 25, 2002, the surgical community lost a dear friend and colleague. C. James Carrico, MD, FACS, was one of those unique individuals who excelled in clinical care, investigative skills, and administrative prowess. A visionary in his time, he will long be remembered for his unexcelled loyalty and dedication to the American College of Surgeons and his influence on surgeons throughout the world.

The son of an educator, he followed in the footsteps of his father, who led the chemistry department at his alma mater, North Texas State University. Jim's leadership ability was soon recognized and, upon graduation from The University of Texas Southwestern Medical School, he was selected to receive the prestigious Ho Din award as the outstanding senior medical student.

During his residency, he was unexpectedly thrust into history as the first physician to care for President John F. Kennedy at Parkland Memorial Hospital on that fateful day in November 1963. True to his character, he kept that in proper perspective, rarely discussed, and never speculated about the circumstances surrounding the event.

Throughout his distinguished career he was always able to balance his professional inter-



Dr. Carrico

ests and responsibilities with unparalleled love, devotion, and dedication to his lovely wife Sue and their three children.

Often seen as a serious individual, he had a sense of humor and a devilish side of his personality that was youthful and refreshing. He often said, "What we do is a serious business; however, we must never take ourselves too seriously." He lived by that dictum and was as comfortable in a pair of jeans tromping around his beloved home on Whidbey Island as addressing a national audi-

ence in formal attire.

His accomplishments are well known. He was the consummate educator who was often called upon to lead many organizations, including the American Board of Surgery and the American Association for the Surgery of Trauma, which he did with diplomacy and grace. He had the enviable ability to bring people together and achieve consensus when compromise was difficult to accomplish.

Despite his intense interest in trauma and critical care, he was first a general surgeon and knowledgeable in all aspects of the specialty. He served as department chair at the University of Washington and his alma mater, The University of Texas Southwestern Medical School in Dallas. Throughout his career, he championed the established principles and ideals that allow both young and old surgeons alike to be able to deliver the highest quality of care to their patients. In his later years, much of his energy was directed toward prevention of injury. He saw this as a major public health issue, and weeks before his passing was tenaciously lobbying this cause.

His work with the American College of Surgeons was legendary. He served on 34 committees, beginning with the Pre-

and Postoperative Care Committee in 1975, and his service culminated with chairing the Board of Regents from 1999 to 2001. Of all his accolades, becoming the President-Elect of the College ranked as one of the most meaningful.

Jim was an inspiration to all who knew him. The manner in which he faced his final battle with cancer exemplified his positive attitude and zest to continue the work that was so important to him.

Earlier this year, more than 300 of his friends and colleagues helped to establish the C. James Carrico, MD, Distinguished Chair in Surgery for Trauma and Critical Care at the University of Texas Southwestern Medical Center in Dallas. This is only the second endowed chair in trauma in the nation and will allow his memory to continue in perpetuity. This chair was a fitting tribute, honoring a person who had unselfishly given so much

of himself and influenced so many in such a humble manner. He was an outstanding, teacher, mentor, clinician, investigator, administrator, friend, and, above all, a devoted son, husband, and father.

C. James Carrico has left an enviable legacy for which he will always be remembered.

Farewell my friend.

Dr. Thal is professor of surgery, University of Texas Southwestern Medical School, Dallas, TX.

Applicants sought for Wylie Scholar Award

The Pacific Vascular Research Foundation is accepting applications for the 2003 Wylie Scholar Award in academic vascular surgery. The award was established by the foundation to honor the legacy of Edwin J. Wylie by providing support to outstanding vascular surgeon-scientists.

Purpose. The award is intended to enhance the career development of academic vascular surgeons with an established research program in vascular disease. The award consists of a grant in the amount of \$50,000 per year for three years. Funding for the second and third years is subject to review of acceptable progress reports. This three-year award is nonrenewable and may be used for research support, essential expenses, or other academic purposes at the discretion of the scholar and the medical institution. The award may *not* be used for any indirect costs.

Eligibility. The candidate

must be a vascular surgeon who has completed an accredited residency in general surgery and who holds a full-time appointment at a medical school accredited by the Liaison Committee on Medical Educators in the U.S. or the Committee for the Accreditation of Canadian Medical Schools in Canada.

To apply. Applications are due by February 1, 2003, for the award to be granted July 1, 2003. Applications for the Wylie Scholar Award may be obtained by contacting the Pacific Vascular Research Foundation, 3627 Sacramento St., San Francisco, CA 94118; tel. 415/771-3541, fax 415/771-3902.

OFFICIAL NOTICE

Annual Meeting of Fellows and Initiates, American College of Surgeons

In accordance with Article I, Section 6, of the *Bylaws*, the Annual Meeting of the American College of Surgeons is called for two o'clock in the afternoon of Thursday, October 10, 2002, in the Moscone Center, San Francisco, CA.

This session constitutes the annual business meeting of the Fellows, at which time Officers

and Governors will be elected, and reports from officials will be presented. Items of general interest to the Fellows will also be presented. Each Fellow is respectfully urged to be present.

John O. Gage, MD, FACS
Secretary,
American College of Surgeons
August 9, 2002

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<http://www.facs.org/commerce/2002/catsplash.html>

For immediate service, browse and order titles online and place your order by credit card through a secured Web server. Or print out your own paper copy of the catalog—and its corresponding order form—and send in your order by mail or fax.

As new titles are added throughout the year, the online catalog will be updated immediately. It's fast, easy to browse, and always up-to-date, the *2002-2003 Publications and Services Catalog*.



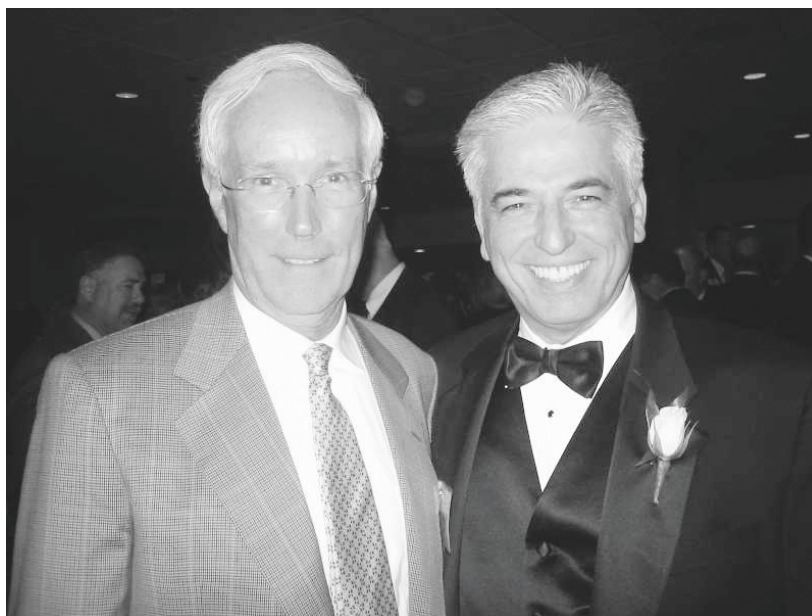
Fellows and facts

John E. Connolly, MD, FACS, and **Sir Robert Shields, MD, FACS (Hon)** were recently named honorary fellows of the Japanese Council for Medical Training. During the same visit to Tokyo, they both served as guest speakers at the annual meeting of the Japan Hospital Association. Dr. Connolly is a thoracic surgeon and professor of surgery at the University of California, Irvine, Medical Center, and Dr. Shields is a general surgeon in Merseyside, UK.

The American Association for Hand Surgery recently presented its clinician/teacher of the year award to **Michael E. Jabaley, MD, FACS**, a plastic surgeon. The award is presented to individuals who have made major teaching contributions in the field of hand surgery. Dr. Jabaley was recognized for his more than 25 years of service as a clinical professor at the University of Mississippi School of Medicine in Jackson, MS.

Earlier this year, **Steven T. Kmucha, MD, FACS**, was elected chair of the California Medical Association's (CMA's) President Forum and was re-elected chair of the CMA's Committee on Quality Care. Dr. Kmucha is a clinical instructor in otolaryngology at Stanford University, in Stanford, CA.

In May 2002, President George W. Bush appointed



ACS Executive Director Thomas R. Russell, MD, FACS (left), congratulates Donald J. Palmisano, MD, FACS, on becoming president-elect of the American Medical Association during the organization's annual meeting this past June.

LaSalle D. Leffall, Jr., MD, FACS, to serve as chair of the President's Cancer Panel. The three-member group oversees the national cancer program and reports directly to the President. In addition to this prestigious position, Dr. Leffall, a Past-President of the College, chairs the steering committee of the National Dialogue on Cancer and the Susan G. Komen Breast Cancer Foundation. Dr. Leffall is a professor of surgery at Howard University Hospital in Washington, DC.

Balak R. Verma, MD, FACS, FRCS(C), recently received the First Millennium Award of "Himachal Ratan" (The Jewel of Himachal) from the All India Conference of Intellectuals. The 20-year-old organization was founded by Indira Gandhi, former prime minister of India, and the award honors individuals who the group determines have made exceptional contributions in the areas of humanism, peace, and patriotism. Dr. Verma, a thoracic surgeon, works full-time as a medical missionary in the Himalayas.

Good News About

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and NCS team up to Help You Collect Your Money

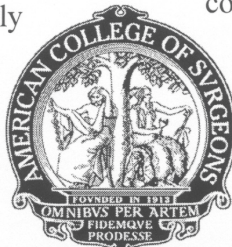
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Liability and patient safety issues to be addressed at Congress

The ACS Committee on Patient Safety and Professional Liability will sponsor two panel discussions during this year's Clinical Congress in San Francisco, CA, that address liability and patient safety issues.

- **Patient Safety: Medical Errors and Improving Patient Safety**, will be held Tuesday, October 8, from 8:00 to 10:00 am. Frank C. Spencer, MD, FACS, will serve as moderator.

Current experiences and new approaches to patient safety will be discussed. Emphasis will be given to methods that any hospital can use, including: (1) the new concept of the "clinical expert" with adverse event committees (other important components include decentralization of authority and continuing responsibility); and (2) a concurrent study of all patient deaths for contributory adverse events. Specific topics will include wrong-site, wrong-patient, and wrong-procedure operations in both inpatient and ambulatory settings.

Topics and panelists are as follows: Preventing Surgical Errors and Adverse Events Using Information Technology, David Bates, MD, FACS, Boston, MA; Eliminate Medical Errors vs. Improve Patient Outcomes: Can We Have It All?, William C. Nugent, MD, FACS, Lebanon, NH; and Building a Patient Safety Program in a University Hospital, Frank C. Spencer, MD, FACS, New York, NY.



Dr. Spencer



Dr. Daly

- **The Surgeon and the Law: Patient Confidentiality—Surgeon, Patient, and Government Perspective**, will be held Tuesday, October 8, from 1:30 to 4:30 pm. John M. Daly, MD, FACS, will serve as moderator.

Patient confidentiality is deemed to be a hallmark of the Hippocratic Oath. Yet, rules of confidentiality and their applications are changing by direct government action. Rules apply not only to physicians but to pharmacies, HMOs, hospitals, and multiple health care providers. The symposium will address these changing rules and the requirements for surgeons' adherence. Penalties for nonadherence to these new rules are severe and far-reaching. Thus, knowledge of this changing en-

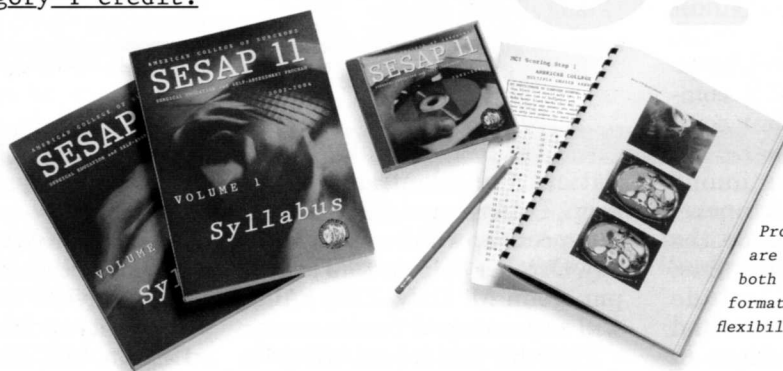
vironment is critical to all practicing surgeons and surgical residents.

Topics and panelists for this session are as follows: The New Peer Review Dilemma: Confidentiality vs. Disclosure, F. Dean Griffen, MD, FACS, Shreveport, LA; Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: Overview, Ira Pollack, San Francisco, CA; Practical Applications of Confidentiality in the Physician's Office, Jacqueline Darrah, MA, JD, Chicago, IL; Health Privacy in the States, Jon Sutton, MBA, Chicago, IL; and The Surgeon's Perspective on the Legal Issues, A. Craig Eddy, MD, JD, LLM, FACS, Missoula, MT.

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Report on physicians as assistants at surgery available

The American College of Surgeons and 14 surgical specialty organizations recently undertook a process to update a study on the need for a physician as an assistant at surgery for all procedures listed in the “Surgery” section of the American Medical Association’s *Current Procedural Terminology (CPT™)* 2002.

Each organization was asked

to review procedure codes applicable to their specialty and determine whether the operation requires the use of a physician as an assistant at surgery: (1) almost always, (2) almost never, or (3) some of the time.

The report, *Physicians As Assistants at Surgery: 2002 Study*, is widely used by third-party payors to determine which procedures require the use of a phy-

sician assistant. This is the fourth edition of the study, which was first conducted in 1994. For a downloadable copy of the 2002 document, go to <http://www.facs.org/dept/hpa/pubs/pubs.html>. A hard copy of the document may be requested by contacting customerservice@facs.org or by calling 312/202-5474.

New service, Congress savings available from ACS Surgery

At this year’s Clinical Congress, the textbook *ACS Surgery*—an official College publication—celebrates the launch of its electronic newsletter, *What’s New in ACS Surgery*. This convenient newsletter highlights key recommendations from the latest updates to *ACS Surgery*. Plus, *What’s New* features a monthly column on a variety of topics from today’s leading sur-

geons. The newsletter also includes a free e-mail alert service to electronically “tap readers on the shoulder” when new information is available online.

Sign up for this service at www.acssurgery.com. Just click on the link “FREE by e-mail” under *What’s New in ACS Surgery*. Or sign up at the Congress at the *ACS Surgery* booth, #1800.

While visiting the booth, take advantage of special Clinical Congress savings. ACS Fellows, Associates, and Candidates can subscribe to *ACS Surgery* at a discounted member price. For additional savings, pick up an *ACS Surgery* savings coupon, available with the Clinical Congress Program Book, and present it at booth #1800.



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IN COMPLIANCE, from page 22

ing the right to revoke and providing instructions on how to exercise such a right; or (2) by including a reference to the practice's privacy notice, if this information is included in the privacy notice.

- The provider may not condition the patient's treatment on obtaining the authorization except for a research-related treatment or if the purpose of creating the information is for disclosure to a third party, such as a life insurance examination.

- The patient must be made aware that there is a potential that the health information may no longer be protected by the privacy rule once it is disclosed by the practice.

Practices that receive an authorization are required to provide the individual with a copy of the signed authorization form. You also need to record that you received the authorization and retain a copy of the form in the patient's file.

Next month, we'll look at the components of the "notice of privacy practices" that will need to be provided to all patients.

Tip for privacy officer

HIPAA requires practices to have contingency plans to ensure confidential data are available following any kind of disaster (floods, fires, and so on) or interruption (such as computer, transmission, and related events). Each practice needs to evaluate where confidential information is kept. Is patient information kept in paper files or in specific software programs? You also need to determine which systems are critical to the operation of the practice. If the computer system is down, do you have access to necessary information so that patients can be treated? If you use the fax machine to order tests and get test results, how will the practice perform those tasks if the fax is broken? 

ACS guidance on HIPAA issues is based on information contained in the "Small Practice Implementation Guide" version 1.2 (<http://snip.wedi.org/public/articles/index.cfm?Cat=17>), © 2001, The Workgroup on Electronic Data Interchange.

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#S8 Solid 14K Gold	\$150	NECKTIE			
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SOCIOECONOMIC TIPS, from page 23

ever, a contractor may develop a LMRP that supplements a national coverage decision.

Before policies are implemented, they are published in draft form for public comment and are presented to the Medicare Carrier Advisory Committees for their review. You may view draft LMRPs on your carrier Web site or at <http://www.draftlmp.net>.

Although LMRPs apply primarily to the Medicare program, some private payors have developed

and published LMRPs for their plans. You may want to contact all your local practice contracts to find out if they have medical review policies available for their providers.

Because local medical review policies contain procedures, the diagnoses for which a carrier believes the procedures are appropriate, and documentation requirements for the procedures, they represent a good teaching tool for surgeons and their staffs. 

The Candidate and Associate Society of the American College of Surgeons (CAS-ACS) invites all residents, residency program directors, and Associate Fellows to attend a symposium on professionalism and how it is taught in the medical environment during the Clinical Congress in San Francisco. The symposium will be held Sunday, October 6, 2002, from 2 to 5 pm.

The speakers will be Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the College's Division of Education, and Michael E. Whitcomb, MD, Senior Vice-President for Medical Education and Director, Division of Medical Education, Association of American Medical Colleges. Dr. Whitcomb is also Editor-in-Chief of *Academic Medicine*, the leading journal devoted to issues relevant to academic medicine. There will be an open-microphone discussion following their presentations.

For more information about this event or the CAS-ACS, contact Peg Haar at the ACS via email at phaar@facs.org or via telephone 312/202-5312.

CAS Symposium
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2002





Highlights of the ACSPA Board of Directors and the ACS Board of Regents meeting

June 7-8, 2002

by Paul E. Collicott, MD, FACS,
Director,
Division of Member Services

American College of Surgeons Professional Association (ACSPA)

Steps have been taken to implement the business plan to establish the 501(c)(6) corporation. Corporate papers—including a Board of Directors slate and *Bylaws*—to establish the entity have been filed with the state of Illinois. A budget has been approved, and additional staffing has been taken into account.

The Officers of the ACSPA Board of Directors (B/D) are: R. Scott Jones, MD, FACS, Charlottesville, VA, President; Edward R. Laws, MD, FACS, Charlottesville, VA, Chair; John O. Gage, MD, FACS, Pensacola, FL, Secretary; John L. Cameron, MD, FACS, Baltimore, MD, Treasurer; Thomas R. Russell, MD, FACS, Chicago, IL, Executive Director; and Gay L. Vincent, Chicago, IL, Comptroller.

The members of the ACSPA Board of Directors (B/D) are (all MD, FACS): Barbara L. Bass, Baltimore, MD; L.D. Britt, Norfolk, VA; William H. Coles, New Orleans, LA; Paul E. Collicott, Chicago, IL; Edward M. Copeland III, Gainesville, FL; A. Brent Eastman, La Jolla, CA; Richard J. Finley, Vancouver, BC; Josef E. Fischer, Boston, MA; Alden H. Harken, Denver, CO; Gerald B. Healy, Boston, MA; Margaret F. Longo, Hot Springs, AR; Jack W. McAninch, San Francisco, CA; Mary H. McGrath, Maywood, IL; Jonathan L. Meakins, Montreal, PQ; John T. Preskitt, Dallas, TX; Ronald E. Rosenthal, Wayland, MA; and Maurice J. Webb, Rochester, MN.

Educating the Fellowship began with a cover story in the April 2002 *Bulletin*, which featured the new ACSPA logo developed in-house. Additional outreach efforts are planned for later in the year, including a membership mailing in the early fall. In addition to dedicated Web pages, educational material will be available at the ACS Resource Center during the Clinical Congress.

The ACS Executive Staff has been briefed by counsel on some of the issues and opportunities that the new corporation presents. One such opportunity is the initiation of a Politi-

cal Action Committee (PAC). The ACSPA B/D approved the creation of a PAC. The B/D also consented that the PAC should be separately incorporated. The PAC's function will be to further the interests of all surgical specialists and their patients.

The ACSPA B/D also approved the establishment of a PAC Board to govern the PAC's general operations and set its goals and priorities. The appointed Board members—all MD, FACS—are: Andrew L. Warshaw, Boston, MA, Chair; Gary M. Bloomgarden, New Haven, CT; Bruce D. Browner, Farmington, CT; James K. Elsey, Thomaston, GA; Josef E. Fischer, Boston, MA; Jean Hausheer, Independence, MO; Jack W. McAninch, San Francisco, CA; Stephen D. McBride, Las Vegas, NV; Joseph S. McLaughlin, Baltimore, MD; Constantine A. Michas, Fresno, CA; Farouk N. Obeid, Detroit, MI; Richard T. Perry, Phoenix, AZ; Thomas V. Whalen, New Brunswick, NJ; Daryl D. Wier, Winter Park, FL; Mitchell L. Willens, Tyler, TX; and Paul I. Wills, Fort Smith, AR.

American College of Surgeons (ACS)

Comptroller's Office

The Regents approved the 2003 budget as presented. There is a projected \$1.6 million budget deficit prior to the projected income from investment activities.

Ad Hoc Committee to Review the Structure, Composition, and Terms of the Board of Regents

The formation of this committee was announced at the February 2002 meeting of the Board of Regents. W. Gerald Austen, Chair, Barbara L. Bass, David G. Murray, J. Patrick O'Leary, Frank C. Spencer, and L. William Traverso—all MD, FACS—are the members of this committee. The committee has held two conference calls, with a third call scheduled for July. Dr. Austen will report on the committee's deliberations and recommendations at the Board of Regents' October meeting.

Executive Committee of the Board of Regents

The committee held its interim meeting April 15 in conjunction with the College's Spring Meeting. One of the many agenda items was the proposal for an in-house travel agent. With such an operation, the College could realize a significant cost savings and deliver a higher level of service to its members. All travelers who would be reimbursed by the College would be requested to use the ACS agent and comply with a travel policy that would be developed and administered by ACS staff. The policy would be sensitive to the needs of the traveler, as well as convenient for the traveler to use. The establishment of this operation was approved.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Robert B. Smith III, MD, FACS, one of the three ACS-appointed commissioners, reported on the March 1-2 meeting of the JCAHO Board of Commissioners (BOC). The following is a brief list of activities that were addressed during the meeting:

- Patient safety, especially wrong-site surgery, is a strong emphasis of JCAHO.
- Core measures as indicators of clinical outcomes are on schedule in their development and implementation.
- JCAHO is moving forward with the creation of ICU measure sets.
- The JCAHO is eager to enhance relationships with practicing physicians.
- It was reported that there has been some exodus of hospitals from JCAHO to "alternative accreditors." This trend is believed to be minimal, but a wake-up call nonetheless.
- Specific disease management certification by JCAHO has officially begun.
- Attention was given to ways to improve the BOC engagement with the home care field. The decision was made to have a home care representative present at the board meetings to serve as a resource and to have one commissioner responsible for providing liaison with that industry.

- The board voted to modify agreements with nine cooperative accreditation agencies, including the ACS Commission on Cancer.
- The board was informed that its executive committee had chosen not to submit an application for JCAHO to compete for a PRO role in the state of Illinois.
- The board voted to change responsibility for scoring sentinel event alerts over to a parallel system of "patient safety goals."
- The JCAHO plans to convene a National Symposium on Patient Safety in the fall.

Charter on Medical Professionalism

The Regents endorsed the *Charter* developed by the American Board of Internal Medicine (ABIM) Foundation, the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) Foundation, and the European Federation of Internal Medicine. In addition to asking societies for endorsement, ACP-ASIM is also asking medical schools to consider adopting its principles in their curriculum. Packets of information on the *Charter* are available through the offices of the ABIM and the ACP-ASIM.

Communications

The 2002-2003 edition of the College's *Publications & Services Catalog* was posted on the College's Web site in early April. The online *Catalog* is the only version available this year.

The Northern California Chapter came online in early May, bringing the known number of chapters with Web sites to 36. A new optional program is being rolled out to interested chapters; template-driven software enables users to cut and paste text from a word processing file into designated text fields. The new program does not require the user to know HTML coding.

Since the deferral of action on an ACS Branding/Marketing-Advertising program, the College held a meeting of a working group on communications issues in conjunction with the Board meeting. Richard J. Finley, MD, FACS, served as the chair of the working

group, which submitted the following recommendations to the Board:

- Create a rapid-response team to develop policies and training for ACS leaders in the areas of public image, patient advisory, and health care policy for the purpose of addressing issues that are in need of a response from the College within 24 hours.
- Develop a public relations business plan.
- Develop a task force to address relationships with specialties and particularly focus on common education and health care policy issues.
- Support the educational programs that are being addressed by the Division of Education.
- Create and implement a timetable that will build value into the Web site and complement the existing educational programs.
- Develop a personalized electronic relationship with the Fellows that can be interactive.

The Regents approved the formation of a rapid-response team. Its members are ACS Fellows Ira Kodner, Chair; Dr. Finley; Dr. Fischer; Dr. Healy; Dr. McAninch; Dr. Russell; Linn Meyer, ACS Director of Communications; and Cynthia Brown, ACS Director of the Division of Advocacy and Health Policy.

Journal of the American College of Surgeons (JACS)

Editorial preparations for 2005, the centennial year for *JACS*, have begun. In keeping with the goals of an educational ACS grant, "Educating Surgeons in Patient Safety," *JACS* has published a call for submissions that requests manuscripts about patient safety issues. The call will continue to run as space allows. *JACS* welcomes individual advertisements about ACS programs and will publish them without charge; all ACS Directors have been urged to send material to the *JACS* editorial office.

An attempt to move the publication's content to a "new technology" Web site has stalled due to problems with the new site. Elsevier Science, the Web site's manager, is reworking

its platform and were to have the revitalized Web site up by August 2002.

Simulators in surgical education

In an effort to gain insight into the value of simulators in medical education, the College sponsored a two-day symposium on the potential utilization of simulators in surgical education. A cross section of individuals including surgeons, educators, engineers, and experts in educational testing participated in this discussion. The group concluded that the overwhelming need facing all surgeons is to improve patient safety and that simulation can play a major role in advancing that aim. It was the conclusion of meeting attendees that simulators can be used well into the future to teach, refine, and test surgical skills. Assessment techniques may be developed to validate these skills and to relate them to patient outcomes with a high level of certainty. In addition, simulators may be joined with techniques that assess judgment and decision-making skills.

Development Program

During the calendar year beginning January 1, 2002, the College received 1,002 gifts totaling \$277,692. Both the number of gifts and the amounts contributed have increased in comparison to the same period last year.

The Regents approved a list of gift opportunities for 2002-2003. Some of the opportunities include support for:

- The Chapter Young Surgeon's Traveling Award.
- The Annual Fund, the Scholarship Endowment Fund.
- The International Guest Scholarship Fund.
- The Owen Wangenstein Fund for Surgical Research.
- The Loyal and Edith Davis Cancer Fund.
- An endowment fund for trauma education in resource-challenged countries.
- The Clinical Congress orientation program for female and minority students.
- Publication of the *Patient Safety Manual*.

- The new President's reception for the new Fellows during the Clinical Congress.

The committee reviewed progress to date in implementing the approved business plan for expansion of the Development Program. The role of the surgeon who will serve as the Director for Development continues to be discussed and reviewed by the committee.

The 2002 Fellows Leadership Society luncheon will take place October 7 in San Francisco, CA. In addition to the Distinguished Philanthropist Award presentation, the luncheon will feature the introduction of the new Fellows Leadership Society life members as well as additional major donors.

Division of Advocacy and Health Policy

Ms. Brown presented an overview of College activities in the legislative arena. A review of the College's efforts to support Health Insurance Portability and Accountability Act (HIPAA) compliance was presented. In addition to a new *Bulletin* column entitled "In compliance," which premiered in May, development has begun on a Web page to link Fellows with primary source materials to aid in their understanding of the regulations.

The status of the development of new practice management courses was reported. The initial course is scheduled to take place in July in Chicago, IL, and September in Miami, FL. A report on the courses will be presented to the General Surgery Coding and Reimbursement Committee at its October meeting. The committee will determine whether it will recommend that the course be incorporated into the 2003 schedule of educational meetings.

The College has launched a nationwide grassroots campaign encouraging surgeons to write their members of Congress, asking them to support the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002 (H.R. 4600). Modeled closely after California's liability reforms, this bill would place a \$250,000 cap on noneconomic damages, impose a three-year statute of limitations, require proportional damages among defendants, modify the collateral source rule,

allow for periodic payments of future damages, and limit attorneys' fees.

Dr. Russell testified before the House Energy and Commerce Subcommittee on Health on February 14. He reiterated the College's support for the Medicare Payment Advisory Commission's (MedPAC's) recommendations and strongly questioned the Centers for Medicare & Medicaid Services (CMS) estimates about the 10-year cost of implementing the commission's plans.

In March, Dr. Russell joined with the CEOs of the major professional organizations whose members are reimbursed under the Medicare physician fee schedule for a meeting with Bill Novelli, CEO of AARP (formerly the American Association of Retired Persons). The groups tried to find common ground on the patient access problems that have started to emerge as a result of continued physician payment reductions.

The College continues to pressure Congress to immediately address both the 5.4 percent negative 2002 payment update and the problematic sustainable growth rate formula. In addition, the College participated in a May 13, 2002, press conference during which Terry Coleman, the former chief counsel of the Health Care Financing Administration (now known as CMS), presented a legal analysis confirming that the agency is allowed by law to correct erroneous figures used in calculations to determine professional payments under the Medicare program. Mr. Coleman's analysis also questioned CMS's decision to include drug costs in the calculation it uses to determine the amount Medicare spends for professional services. The analysis was funded through specialty society contributions made to the AMA-led coalition effort.

The AMA's work group on evaluation and management codes held a public meeting on May 17 to hear testimony on revising the visit coding system. The College was one of nine surgical societies identified in advance to testify and presented a coding proposal based on the patient's presenting problem. The documentation required under such a coding sys-

tem would be reduced markedly; the number of codes would remain the same.

The College drafted a letter that was cosigned by more than 40 medical and surgical societies, nonphysician groups, and others, which provided information to MedPAC on the use of first assistants and outlined the problems with proposals for bundling these services. At the MedPAC meeting on April 25, 2002, commissioners dropped the recommendations for bundling the assistant at surgery payments.

Last December, the Department of Health and Human Services (HHS) announced that it had appointed an Advisory Committee on Regulatory Reform to recommend streamlining requirements set by the Food and Drug Administration and CMS. The committee requested written comments on regulatory burdens and will hold four public hearings to gather more information before making its recommendations. In his letter to the committee, Dr. Russell requested that minor modifications be made to two Medicare regulatory requirements that are especially burdensome to surgeons. One is to clarify whether it is necessary for the surgeon to obtain an advanced beneficiary notice from the patient when he or she is being referred to another physician for a face-to-face service. The second issue relates to the 23 national coverage decisions on clinical laboratory tests that will become effective this November. The College requested that the coverage decisions be clarified to indicate that the preoperative testing is recognized wherever it is appropriate.

In February, the HHS Office of Civil Rights republished its policy guidance on persons with limited English proficiency that clarifies the legal obligation health care providers have in providing oral and written language assistance to these patients. The College submitted brief comments that raised concerns about the financial burden that the requirements place on physicians. The comments acknowledge the importance of meaningful communication between health care professionals and

their patients, but pointed to the financial and logistical difficulties of providing professional interpretation services for patients who lack proficiency in English, without any mechanism to reimburse physicians for the cost of these services.

The College is gathering signatures from members of Congress on a letter of support for increased funding for state trauma care system planning and development grants outlined by Title XII (Trauma Services) of the Public Health Service Act. Thus far, 134 representatives and 45 senators have signed this year's letter to House and Senate appropriators. The College also is working with the key committees to reauthorize Title XII. In addition, the College is working at the state level to secure a governors' sign-on letter that will be sent to Senate HELP Committee Chair Ted Kennedy (D-MA) and House Energy and Commerce Committee Chair Billy Tauzin (R-LA), urging reauthorization of Title XII.

The College continues to focus on the Emergency Medical Treatment and Active Labor Act (EMTALA) and physician on-call issues. The College is a member of an EMTALA task force, which continues efforts to reform the statute.

At the direction of the Board of Regents, the College joined the National Quality Forum to ensure that surgeons were active participants in the development and implementation of proposed clinical quality and outcomes measures that would be shared throughout the nation.

The College's Health Policy Steering Committee (HPSC) reviewed its subcommittee's draft position statement regarding surgery's response to the current nursing shortage. The HPSC suggested minimal changes to the draft. The HPSC also offered feedback on a College response to the Accreditation Council of Graduate Medical Education's (ACGME) preliminary report on resident duty hours. The committee believed that surgery needs maximum flexibility in terms of hours, emphasizing that residency is an education, not a job, and that greater em-

phasis should be placed on adequate supervision, backup systems, and the need to monitor and limit moonlighting.

The 2002 annual meeting of the American Medical Association (AMA) House of Delegates was held June 15-20 in Chicago, IL. As a result of the biannual balloting process, the College's delegation has been reduced from five to four. The College was represented at the June meeting by four delegates and two alternates—all MD, FACS—LaMar S. McGinnis, Jr., Charles Logan, Richard Reiling, Amilu Rothhammer, Dr. Russell, and Thomas Whalen. Chad Rubin, MD, FACS, will continue his service as the College's representative to the AMA Young Physicians Section.

The College is submitting a resolution to the House of Delegates and the Young Physicians Section calling on the AMA, in collaboration with the specialty societies, to advocate that Medicare and other payors reimburse all appropriately trained physicians regardless of specialty for performing diagnostic sonography in situations with defined clinical indications.

Division of Education

Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, gave a status report that included the mission, vision, and goals of the division. The Regents approved revisions to the ACS Statement on the Use of Animals in Research. The revisions are based on recent changes to the Federal Animal Welfare Act, Regulations, and Standards with respect to the classification of and emphasis on the animal's level of pain and distress. The U.S. Department of Agriculture has also added "teaching" and "education" to the Act and no longer includes these items under the realm of "research."

Planning for the Clinical Congress in San Francisco, CA, is progressing well. The experiential, skills-oriented courses have been separated from the didactic courses in the program listings as a first step toward greater educational distinction between these two types of courses.

A review course in urology will be piloted at the Clinical Congress. Plans are under way to produce specialty-specific informational brochures with the help of the chairs of the respective advisory councils to target members of various surgery specialties. A major change in the medical student program is planned, and an open invitation will be sent to all medical schools across the country inviting each school to send students to the Clinical Congress.

Steps are under way to establish a unique character for future Spring Meetings, with greater emphasis on practice-related topics and experiential courses that focus on the acquisition and maintenance of skills. In addition, beginning in 2003, the Spring Meeting will begin on Saturday and conclude on Tuesday. This modification will take the surgeon away from practice one less weekday.

The American Board of Surgery (ABS) was invited to the College to participate in an examination content review process to evaluate the match between items of the last recertification examination of the ABS and the Surgical Education and Self-Assessment Program (SESAP) 11. The board has appointed a liaison to work with the SESAP Committee and the division to strengthen the collaboration between the ABS and the College.

The opening session of the 2002 Spring Meeting was videotaped for Web-casting. The number of times the program has been accessed attests to its very positive reception. Opportunities for Web-casting of other educational programs are being pursued. Opportunities to offer CME credits for participation in international-based educational programs will also be explored.

The ninth Surgeons As Educators Workshop was offered February 23-March 1, 2002. The course was very well received. Summative evaluations for the participants were extremely laudatory. The comments from the attendees were also overwhelmingly positive, and planning for the 2003 workshop has begun.

A graduate student has been identified to

serve as assistant editor to create a "Manual for Residents" and a "Manual for Instructors" from the publication, *Ethics Curriculum for Surgical Residents*. The student will work closely with the authors of various chapters and the division to accomplish this task. The curriculum will then be ready for pilot-testing at a number of different institutions. Ongoing educational support for the instructors during pilot-testing and implementation of this curriculum will be provided through the division.

The Committee for the Forum on Fundamental Surgical Problems held a retreat February 7 to address concerns relevant to its future. The charge was to perform an analysis, develop objectives and goals, and recommend steps that could lead to the Forum's reinvigoration. Several of these steps have been initiated, including:

- Publishing all the accepted abstracts in a September supplement of *JACS*.
- Highlighting the individual to whom the Forum is dedicated annually in the *JACS* supplement with the individual's picture and biosketch.
- Sending the supplement to the entire Fellowship as a regular issue of *JACS*.
- Distributing the supplement to all attendees of the Clinical Congress at the registration desk.
- Providing a special gift to the individual to whom the Forum is dedicated at the time of the Clinical Congress.

The Society of American Gastrointestinal Endoscopic Surgeons (SAGES) was represented at the Regents' meeting by Jeffrey H. Peters, MD, FACS, who presented a program overview of SAGES' "Fundamentals of Laparoscopic Surgery" course. ACS/SAGES' administration of this program will be brought back to the Regents at their October meeting.

The Council of Medical Specialty Societies (CMSS) approved a statement relating to resident duty hours at its meeting on March 23. In summary, the CMSS endorses efforts to limit the work hours of residents in a responsible way—residents must be properly super-

vised and not overworked while, at the same time, properly educated and trained. Because not all specialties are the same, recognition must be given to differences in training requirements. The statement also indicated that the CMSS endorses the current attempts of the ACGME and its member organizations to set appropriate limits on resident work hours, that the CMSS endorses the concept of limiting the time-on-task responsibilities of residents and for providing adequate rest periods. The CMSS does not support the imposition of federal or state mandates to set limits on work hours.

Division of Member Services

Dr. Collicott gave a status report on the activities of the division. Currently, he is working with Philip T. Siegert, MD, FACS, on the Ambulatory Surgery in the Office Setting Consensus Project under the aegis of the National Patient Safety Foundation. This project deals with the prevention of unnecessary deaths related to office-based surgery.

The Executive Committee of the Board of Governors has proposed a reorganization of the Governors' committees. This committee also suggested that the Governors' committees have mission statements to better reflect the current issues under consideration by their board.

The New Governors' Orientation occurred in conjunction with the College's Spring Meeting in San Diego, CA. The orientation will not be held in 2003.

The Nominating Committees of the Fellows and the Board of Governors have submitted their final slate of nominees for the pending vacancies on the Board of Regents, for ACS Officers, and Executive Committee members of the Board of Governors. The names of the nominees remain confidential until they are announced October 9 and 10 during the Clinical Congress.

Dr. Collicott and Ms. Vincent, along with consultants, have met several times with professional liability insurance companies to

address the malpractice crisis in the U.S. today. The problem is not necessarily the insurance companies, but rather the laws within the states regarding the tort system. This situation again emphasizes the need for tort reform at all levels in the U.S. The College is currently pursuing an insurance program that it could endorse and that could provide a unique product for its members. Proposals for a sponsored professional liability program have been submitted and are under consideration.

In December 2000, the College began to investigate a surgery resident loan program. Initial examination revealed several negative factors, one of which was that the College did not have enough information about residents' loans or their net debt need or rate to determine the needs of its residents and how to address these needs. Development of a survey document on debt management issues was initiated but not finalized, and ultimately the surgery resident loan program was removed from the College's priority list. In April, the College received a proposal for a resident assistance loan program, and as a result is in the process of reviewing the status of the first program and what information is needed to move forward at this time.

In the area of membership recruitment:

- Mailings were sent to all chairs of departments of surgery and to all surgical program directors to enlist their support in resident and junior staff management.

- The ACS application form has been shortened and the application process streamlined; the forms can be downloaded from the College's Web site.

- The membership categories "Dues Fully Paid" and "Age Limit" have been combined and renamed "Senior," and a category of "Inactive" has been created for those individuals that the College is unable to contact and who are unresponsive to mail; all ACS mailings to this latter group will be eliminated.

An in-house committee was formed to ana-

lyze and follow up on the membership survey conducted in 2001 as a part of the strategic planning process. This survey was an outgrowth of the recommendations of the Regental task force on membership and member benefits. The survey was sent to the members of the Board of Regents, all Governors, Advisory Council members, general surgery program directors, chapter officers, and standing committee members and selected Fellows. The committee held five separate meetings to discuss the report, to evaluate its validity, and to make comments, suggestions, and recommendations. The committee noted that the membership in the College accounts for only about 22 percent of all American Board of Medical Specialty (surgical) certificate holders. Following are some of the recommendations made by the committee in response to various observations:

- Meet the needs of all members, both academic and community-based.
- Use passwords rather than membership numbers to access "Members Only" side of the Web site.
- Continue to provide more online services for all ACS members.
- Provide online access to personal attendance records at College-sponsored programs.
- Consider major changes in the Spring Meeting format with more "hands-on" courses.
- Continue to review and revise online patient information brochures.
- Develop a State Legislative Action Center similar to the Federal Action Center.
- Improve the maintenance of the Job Bank.
- Continue to build on efforts to encourage chapter advocacy activity including but not limited to regular College leadership/staff participation in chapter meetings and development of advocacy action kits relating to specific state legislative issues.
- Consider discount of membership dues paid electronically.
- Increase electronic publications.

Candidate and Associate Society, American College of Surgeons (CAS-ACS)

The Regents approved the Statement on Residency Work Hours drafted by the CAS-ACS. The statement is consistent with recommendations published by the ACS in 1994 concerning Surgical Residencies and the Educational Environment. The statement appears on page 21 of this issue of the *Bulletin*.

Committee on Diversity Issues

The Regents approved the following mission statement: "To study the educational and professional needs of underrepresented surgeons, and to seek relevancy and support by the American College of Surgeons through mission, policies, and programs."

The Regents also approved the following ACS Fellows as members of the Committee on Diversity Issues: Myriam Curet, Chair; Juan Cendan; Edward Cornwell III; Fernando Diaz; Margaret Dunn; Joseph Espat; Debra Ford; Karen Johnston; William Pearce; and Sylvia Ramos.

Advisory Councils for the Surgical Specialties

The Regents approved the deletion of the Statement of the Advisory Council for General Surgery to the Board of Regents of the American College of Surgeons and approved a revised statement as recommended by the Advisory Council for General Surgery. The revised statement includes revisions to the text addressing training and skills.

Nine of the 12 advisory councils have held their interim meetings. The main topics of discussion were resident duty hours, professional liability, Medicare reform, and the Surgical Forum. The advisory councils have been supportive of the ACGME workgroup's recommendations. The advisory councils continue to propose educational programming for the Clinical Congress. Also, the Advisory Council for General Surgery is actively working with the American Board of Surgery on the development of the maintenance of certification process established by

the surgical boards. The Advisory Council for General Surgery agrees that the link between the ACS and the surgical boards is important and that specific ACS educational programs developed and offered should properly identify and acknowledge the maintenance of certification efforts.

Chapters

Numerous chapter meetings have been held both domestically and internationally since February 2002, many of them celebrating their 50th anniversary. The College expresses its gratitude to the Officers, Regents, and Governors who donated their time and energy to represent the ACS and contributed to making those meetings successful.

The Chapter Leadership Conference was combined with the Young Surgeons Meeting at the College headquarters in May. Approximately 125 individuals attended. The possibility of holding the meeting in Washington, DC, is being examined for 2003.

In cooperation with the Division of Education, an off-site ultrasound course will be piloted immediately before the Connecticut Chapter's annual meeting. Also, in conjunction with the Division of Advocacy and Health Policy, a practice management seminar is being planned for availability to the chapters in the future.

The Chapter Web Site Management Program is undergoing a revision to make it easier for chapters to maintain and update their respective Web sites. The College used the same contractor for this project that it uses for its own Web site.

An Advanced Trauma Life Support® introductory program was presented in Columbia, SC, in preparation for introducing the course into Germany and Hungary. This program provides an excellent tool for member recruitment internationally.

The Australia and New Zealand Chapter of the ACS Travelling Fellowship was awarded this year to Christopher R. Forrest, MD, FACS. Mark D. Duncan, MD, FACS, is the designated alternate. The purpose of this Fellowship is to

encourage international exchange of surgical scientific information.

The Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons was awarded to Caren E. Gaines Wilkie, MD, FACS. John M. McBee, MD, FACS, is the designated alternate. The Oweida Scholarship provides an award of \$5,000 to subsidize the participation of a young rural-based Fellow or Associate Fellow in attendance at the annual Clinical Congress.

The Regents approved a new exchange program, the ACS/Japan Traveler Exchange, sponsored jointly by the College, the Japan Surgical Society, and the ACS Japan Chapter. The financial support is for ACS travelers for a three-year period. The Japan Surgical Society and the ACS Japan Chapter will be responsible for support of the Japanese travelers during this time period. The first ACS traveler will attend the annual meeting of the Japan Surgical Society in April 2003.

Division of Research and Optimal Patient Care

The Office of Evidence-Based Surgery, Cancer, and Trauma function under this division. Margaret M. Mooney, MD, former Interim Director of the Office of Evidence-Based Surgery, left the College to accept a position with the Cancer Therapy Evaluation Program of the National Cancer Institute. A search is under way for a new director for this office.

The Agency for Healthcare Research and Quality's first annual Patient Safety Research Conference for all patient safety grantees took place February 7-8. Representatives from the ACS attended to present the progress to date on both the Patient Safety in Surgery Study and the Resident Work Conditions Study.

The Surgeons Palliative Care Workgroup is supported by a grant from the Robert Wood Johnson Foundation. The primary focus of the 21-person workgroup is to raise the awareness of practicing surgeons to the various roles and responsibilities that they can assume in assisting patients with serious, life-threatening conditions.

Highlights, continued

The Young Surgical Investigators Conference took place March 8-10 and was attended by approximately 110 participants. The course evaluations were all very positive and indicated a successful meeting. The next conference is being planned for the spring of 2004 and will be chaired by Colleen Brophy, MD, FACS.

Following approval by the Board of Regents, the Surgical Research Committee has taken on the responsibility for oversight of the efforts of the Office of Evidence-Based Surgery. The Office of Evidence-Based Surgery now also provides staff support to the newly formed Committee on Perioperative Care, formerly the Committee on Processes of Surgical Care. The Regents approved the new name of this committee along with a relative document that states the organization, objectives, and activities of the committee.

The Commission on Cancer has embarked on a proactive evaluation and revision of the current cancer program standards. Concerns were identified with the current standards, and changes were recommended. July 1, 2003, is the projected time line for implementation of the recommendations.

The Committee on Trauma (COT) held its annual meeting April 11-13. The COT's complete annual report will be forthcoming this summer. The 24th Annual Residents Trauma Papers Competition was held during the COT meeting. Twelve regions submitted winning papers, and awards were presented in the basic science category and the clinical research category. A special session was undertaken with the COT chair, in anticipation of the change in the COT leadership, to create a strategic planning process for the National Trauma Data Bank™, the design of the Office of Evidence-Based Surgery—with an emphasis on guidelines and clinical trials, and the development of a committee on disaster management. J. Wayne Meredith, MD, FACS, and Gregory J. Jurkovich, MD, FACS, were named Chair and Vice-Chair, respectively, of the COT.

The Regents approved "Withholding or Termination of Resuscitation in Prehospital Traumatic Cardiopulmonary Arrest," a proposed

joint position statement (and publication of the same) of The National Association of Emergency Medical System Physicians and the ACS Committee on Trauma. The need for consensus on withholding or termination of resuscitation has been an issue and continues to consume resources and expose health care workers to potential injury. The document is evidence-based and will create guidelines to allow paramedics to terminate resuscitation.

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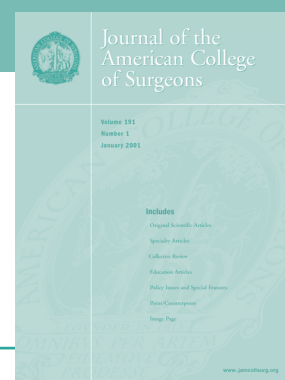
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- PG 30:** A Surgeon's Personal Guide to Risk Management and Trial Participation



Next month in *JACS*

The October issue of the *Journal of the American College of Surgeons* will feature:



Collective Reviews:

- Endovascular Therapies: An Update on Aortic Aneurysm Repair and Carotid Endarterectomy
- Neurofibromatosis: Implications for the General Surgeon

Education:

- Effects of Limited Work Hours on Surgical Training

Original Scientific Articles:

- Life-Sustaining Capacity of Human Polymerized Hemoglobin when Red Cells Might Be Unavailable
 - Concordance and Validation Study of Sentinel Lymph Node Biopsy for Breast Cancer Using Subareolar Injection of Blue Dye and Technetium 99m Sulfur Colloid
 - Intraoperative Parasympathetic Nerve Stimulation with Tumescence Monitoring During Total Mesorectal Excision for Rectal Cancer
 - Anorectal Dysfunction after Surgical Treatment for Cervical Cancer
-